PRINTED: 09/10/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0155	A. BUILDING: _____ B. WING _____	R-C 08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S RESIDENTIAL CARE HOME	243 NORTH PROSPECT STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R100}	Initial Comments: An unannounced on-site survey was conducted by the Division of Licensing and Protection on 8/26/15 as a follow up to the survey of 7/6/15 in which regulatory violations were identified. A complaint investigation was conducted in conjunction with the follow up survey. There were no regulatory violations identified related to the complaint. The following regulatory violation resulted from the follow up survey.	{R100}		
{R126} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to provide supervision of 1 of 2 applicable residents in a manner to assure the resident's identified safety needs were met. (Resident #1). Findings include: Per record review staff failed to adequately monitor the location of Resident #1, which led to his/her subsequent elopement and absence from the home for a period of approximately 3 hours and 40 minutes, without staff knowledge. The resident's most recent assessment, dated 3/5/15, identified him/her with moderate impairment in his/her cognitive ability for daily decision making.	{R126}		

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{R126}	Continued From page 1 A Care Plan Conference was held on 4/16/15 and indicated the resident was at risk; "Because [s/he] loves to walk [s/he] is at risk of walking off the premises and getting lost". The record revealed the resident had a history of wandering as evidenced by his/her disappearance on 5/21/15 when s/he had gone for a walk and was returned to the home approximately 2 hours later by police after staff had been unable to locate him/her. Despite this identified risk a subsequent progress note indicated that on the night of 8/16/15 at 11:50 PM local police had contacted the home to notify staff they had found the resident wandering a distance from the home. The note further indicated that staff had no idea the resident had eloped or how long s/he had been missing from the home. During interview the DNS (Director of Nursing Services) stated that rounds are conducted by both an off-going and an on-coming caregiver, together, at the change of every shift to determine presence of each of the residents. However, although both the caregivers had documented the presence of Resident #1 during the 11:00 PM shift change rounds on 8/16/15, both caregivers later acknowledged they had not physically seen the resident at that time. In addition, despite the fact that a caregiver had documented that resident rounds had been conducted every two hours during the 8/16/15 evening shift, in accordance with the home's policy, the DNS and the Administrator both acknowledged that per review of a video recording it was determined that Resident #1 had exited the facility without staff knowledge at approximately 8:10 PM and was not returned until approximately 3 hours and 40 minutes later, indicating a failure, by staff to adequately supervise/monitor the resident.	{R126}	- As of 8/20/15, we have changed the activation time of our door alarm system from 9:00 pm to 8:00pm. We have also had our alarm system vendor, increase the system testing from weekly to daily. - As of 8/20/15 we have contracted with Care Trak Northeast, to use a GPS tracking system to locate Resident 1 should he elope. The Burlington Police Department has the locator device. - As of 8/30/15 Resident 1 has 1:1 private duty from 4:00pm-8:00pm 7 days a week. When the private duty care givers are not here we do hourly checks. To ensure that hourly checks are being completed, Med Tech verifies with caregiver hourly and both sign the assignment sheet (see attached) attesting that the checks and other tasks were completed. These hourly verifications will be on-going until Resident 1 has found other placement. - We are actively seeking nursing home placement and have requested a legal guardian to help Resident 1 make decisions. We also are looking into the VNA adult day program as an option for Resident 1. -Both employees were given a corrective action plan for not checking resident at change of shift and documenting that it was complete and he was in bed. POC approved 9/24/15 Bonnie Howe	

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{R126}	Continued From page 2 *This is a repeat deficiency*	{R126}	Per TC with Administrator at 3:38 PM on 9/24/15 Completion date for POC - Bonnie Howe RN	9/24/15